1D13 - Ruth Sleeper

15d - Speeches, 1963-1967

3/28/63

AFTER TEN YEARS

Many of you here today, as I do, remember clearly the beginnings of this Council of Member Agencies in 1953. Representatives of 66 member schools met to organize. Many of them were uncertain that such an organization could hold potential for the support and guidance needed. All were eager to work together toward the improvement of the diploma program in nursing.

The rapid series of events in the late 40's and early 50's had left many loyal supporters of the hospital school shaken and confused. And this confusion was reflected not only in the concern for the ability of such a new organization but in a feeling of isolation and insecurity. What about our separation from the collegiate organization? Did the associate degree schools really belong in this Council? Would the American Hospital Association ever give its blessing to the organization so that all schools could participate?

Only a short time before, the Brown Report "Nursing for the Future" had been published. To those closely involved with the diploma schools this Report was in all probability the most important outcome of the "Comprehensive Program for Nation-Wide Action in the Field of Nursing," published in 1945 by the National Nursing Planning Committee of the National Nursing Council for War Service. The Brown Report had not been easy for the diploma schools to accept. It had urged further development and expansion of the college programs. It had emphasized the need for more positive steps in accreditation. It had reiterated the too seldom remembered findings in the Rockefeller Report of 1923 and the Grading Report "Nursing Schools Today and Tomorrow", published in 1934 that " . . . .nursing education remains apprenticeship training."

Coming almost simultaneously to the schools and to the general public was the "School Data Analysis - Nursing at the Mid-Century," a publication of the National Committee for the Improvement of Nursing Services. This report had been even more traumatic because for the first time nursing schools were classified and the classification was given publicity. Accreditation had not seemed too threatening. In fact many good schools had not applied for accreditation at this time. Only 190 out of 1,100 schools had ~~in fact~~ been accredited. But now complacencies, securities, and even loyalties were shaken.

Meanwhile the accrediting services of the A.C.S.N., the N.L.N.E. and the N.O.P.H.N. had been merged. and the accreditation program of the Cath Hosp Ass'n was also to be a part of the ~~new~~ developing plan The Manual of Accrediting Educational Programs in Nursing Leading to a Diploma was published and representatives of 1,100 schools of nursing had met in the regional conferences to learn the details of the new service. A new concern for accreditation and self-improvement had begun to emerge. Schools challenged their classification in the School Data Analysis and demanded an opportunity to demonstrate their improvement through the accreditation procedure. The School Improvement Program was ready to be launched in July, 1951. The field was prepared and waiting hopefully.

Without doubt the most important factor in the beginning of the School Improvement program was Accreditation. There were two phases of accreditation to be dealt with. The program of "full accreditation" could serve only a few, for many schools were not ready to meet these criteria. But this of necessity was a program to be maintained and strengthened. The program of "temporary accreditation" had also to be planned and introduced. Temporary accreditation, like a stepping stone to full accreditation, demanded less rigorous action or standards, but was designed to give a school the

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stimulation and help of the survey. The self-evaluation involved brought new vision and new ideas. Finally there was the encouragement and sheer satisfaction which came with public recognition of the school's program even though this was temporary. That 831 diploma programs applied for temporary accreditation seems evidence enough that the schools had recognized their needs and had gained hospital support to participate.

This then was the situation in the broad field of diploma school education for nursing when the representatives of those 66 schools came together to form a Council of Member Agencies. Those who looked could find positive indices of change. Instead of 190 accredited schools including degree and diploma schools, there now were 154 fully accredited and 577 temporarily accredited diploma programs.

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The goal of school improvement was not to be achieved by the accreditation program alone.. There was to be help for the individual schools. Consultation services were planned. There was to be a new outreach for assistance. In part this was provided through self-help in group meetings in the States, and in regional meetings. There were questionnaires to be answered and reports to be submitted by the schools which were basic to self-study and self-evaluation. There were new tests to give tangible evidences of student growth, new publications to stimulate and give assistance. There was a Cost Study to show for the first time the actual cost of educating a nurse in a three-year hospital controlled school.

All of this of course takes money. As I compare the program of the N.L.N.E. in the 1940's with the program of the N.L.N. Department of Diploma and Associate Degree Programs, I am always a little appalled. What can make such a difference? In the last year of the N.L.N.E. accrediting

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program there was only $12,500 dollars for all the activities of that accrediting service. And well I remember how hard it was to raise even that. When the National Nursing Accrediting Service was first formed only $38,000 was available for this entire service, a 300% increase, but still a pitifully small amount for all programs. From 1951 to 1960 the years of most rapid change, $11,000,000 was allocated to school improvement; a large share of which was to support the program of temporary accreditation and consultation for the diploma schools. It is noteworthy indeed that $3,500,000 of this was raised by the N.L.N. through Foundation and Federal Government grants.

A review of progress for this Department will include the growth of the Associate Degree Program. For many years the N.L.N.E. and in turn the N.L.N. had cooperated with the American Association of Junior Colleges, each organization stimulating and assisting the other in planning first for Junior College cooperation and then for participation in nursing education. In 1955 the N.L.N. assumed responsibility for guiding the development of Associate Degree Programs in Nursing Education. Lessons learned in both diploma and baccalaureate degree programs over the years guided the action of the N.L.N. in this pioneer venture. An expert in junior college administration was employed as consultant to junior college presidents or other college administrators. Later a consultant in nursing education was also added to this staff. So were the acceptable standards and sound approaches to nursing education made known to those entering this new aspect of junior college and nursing education. Nursing and junior college literature would appear to indicate that given the will to do, knowledge and time, and financial support, nursing education like other forms of education can be developed soundly. Mistakes of the past made when each institution followed its own trends without adequate knowledge of possible pitfalls can be avoided.

I cannot in this brief time recount all of our progress. The schools as agency members have shared through their representatives in the setting of standards and the formulation of programs. "The Criteria for Evaluation of Educational Programs Leading to a Diploma" and those leading to an Associate Degree are in significant part our own choices. Five times we in the diploma programs have had opportunity to give our suggestions to help.

The N.L.N. Testing Service has also had our help through members of this group who have helped to write test items or to make their thoughts about the tests known.

The Cost Study yet to be published has already helped many schools as they participated,or were stimulated individually to begin their own analyses.

The Faculty Study has served to remind us of a need basic to the growth in enrollment and in the achievement of excellence in our schools, a need for which we should now be making more and different plans than we have made in the past.

There have been studies, research, and publications; all to help us in our two programs to move forward. There have been disagreements, concerns, over the Department or decisions of the Division of Education or the N.L.N. Board policies. But our progress in the past is indisputable. We have goals. We have programs to implement the goals. We have schools better prepared than ever before to take the next step. That the future of the diploma program is not entirely clear to us all should not hold us back. There is much still to be done to make and keep our schools in step with

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good educational principles and methods today. That we do not know exactly how our goals should change for 1980 should not retard our efforts. If we continue to move forward we shall be ready for whatever the 80's or the 90's or the 21st century may ask of us. It has been said that ". . . the greatest of all mistakes is to do nothing because you can do little." Surely as the past has shown our potentialities for progress, the future will show us both the new goal and the ways to achieve it.

RS:BF
3-28-63

CAPPING

BOSTON UNIVERSITY SCHOOL OF NURSING

SATURDAY, FEBRUARY 15, 1964

RUTH SLEEPER, R.N.

The thoughts I have for you tonight were first conceived while I was in New York two weeks ago to attend a meeting of the Board of Directors of the National League for Nursing. So, the message I have for you is a letter begun at that time.

Dear Students:

I am here in New York for a week of meetings with about twenty nurse administrators, nurse educators, college professors, and lay men and women. Our discussions cover all fields of nursing, hospital, public health, occupational health, and nursing education, undergraduate and graduate. Conversation as in any such group deals with needs for nurses and nursing in all fields, provisions for financial support of nurse students and nursing education in all types of programs, continuing education of nurses, both in advanced academic programs and day-by-day while at work. As at all such meetings we came again to the question - what is nursing? What is nursing to be in 1980, 1970, or even 1965? What education is necessary to prepare the nurse to give what patients should have in the future?

Now I am not going to discuss the definition of nursing with you tonight. Your instructors I am sure did this with you many weeks ago. You are familiar now with the differences in nursing service and nursing care. You are beginning now to learn the components of nursing care, and you may at times observe the results of the services carried on sometimes by other nursing personnel which undergird, facilitate, and often make possible the nursing care given. In fact, these services may even determine in some part the degree of effectiveness you can achieve in your patient care. You must by now also begin to sense the part in nursing care played by those whose

preparation has been in a single purpose school with heavy emphasis on the more technical aspects of nursing.

In short, you may now realize that nursing is not a single function but rather the cooperate effort of many people. As one whose work is in a service agency, I should like as you take this step of recognition to share some of my thoughts with you, a future member of a nursing staff. Although my observations have been made in a hospital, some of what I have seen might well have been observed also in a public health agency. I must confess that terminology troubles me at this point. What is a public health agency? What is a community agency? True, these terms are usually applied to non-hospital nursing services. But actually, the hospital is equally a community service. It is supported either by public taxation or by public gifts and patient payments. It is in short supported by the community to serve its people. It is in fact an excellent example of an agency built by and for the community and is just as truly a public or community service as the visiting nurse or public health nursing service, the well baby clinic, or the mental health clinic.

There are of course differences. The nurse who works in a visiting nurse service deals in part with illness, perhaps to a greater degree with prevention and promotion of health through direct service to patients and families and through teaching. The hospital,too, serves these same purposes. Its major function appears to be the care of the sick. But note the total care given. A patient comes to the hospital with a broken leg. Surely the hospital cares for more than the broken leg, more than the physical and emotional response to the pain and the incapacity resulting from inability to walk. The patient has a complete physical - a health examination. If the

patient shows evidences of disease or lack of function in other parts of his body these conditions are noted and care is given, both emotional and physical. So combined with the cure of the original illness is a program for prevention of illness and promotion of health. There may be teaching of the patient's mother. There is rehabilitation for living at home, or for work. So as I speak of your relationship now to nursing and hospital, I shall in my mind classify both the hospital and the visiting nurse service as community health agencies. I shall think of a nurse as a health worker who belongs to the community, working in one instance in an area circumscribed by hospital walls only for the purpose of holding together the equipment and services needed momentarily for the patient. But hospital walls which are figuratively speaking porous to permit a kind of community osmosis which allows patients, families and services to flow freely in or out as the need dictates. And herein lies one of the major differences. The public health nurse goes to her patients in that section of the community in which the patient resides. The hospital nurse receives those who come to her from all parts of the community. The public health agency can to a great degree control the numbers of persons to whom the nurse will go. The community recognizes no limitations in sickness. Many factors accelerate their coming, an epidemic, the unavailability of doctors, the accident, the local disaster, the increasing numbers of aging people with their chronic diseases, the more effective health education which encourages people to take advantage of new medical and surgical techniques. And so they come, more and more because it is their community agency, their public service for health.

And it is this voluntary flow of people which creates the hospital, which makes it different from other public health facilities. It is this

voluntary movement of people into the hospital, the free choice of people to seek admission which creates the very structure of the institution with its departments, its several professions, its supporting services. The very numbers of patients and services demand organization, set up a system, create an association of peoples who can perform their particular functions because others make their work not only effective but actually possibly at all. A review of the early hospital and its structure shows how much less interdependence once prevailed. Each worker then carried on most of his own activities; the doctor, for example, needed no bacteriology laboratory service. What little laboratory work was done to confirm or make a diagnosis he, himself, could do. The nurse was the social worker, the dietitian, the occupational therapist, insofar as such activities were carried on or even conceived.

Now I am concerned for you at this stage as you begin even in a small way to fit into a group responsible for patient care. What are you seeing? Do you find many separate professional and non-professional islands, or an interdependent group of people with a common goal; i.e. an ultimate goal of patient cure? Do you see an organized group led on the one hand by a doctor, on the other by a nurse. Does the hierarchical structure controlled by persons far removed from the unit on which the patient stays seem a part of this interdependent group? Can you see why all this exists?

If each one of you were to hold this letter in your own hands I should draw a diagram for you. I should draw an organization pattern for a hospital, or a community health agency. My pattern would not have been the usual one with Board of Trustees, Hospital or Agency Director and Director of Nursing, Doctor, etc. These all have important responsibilities. In fact each one of these in turn carries a responsibility for all personnel and for you, too, as a student having experience in the patient units. But this is

not the pattern I would draw this time. All these individuals, important as they are in securing money, in meeting legal requirements, in providing equipment and space, still do not dictate the program for the agency. The dictator, if one exists, in a hospital or a visiting nurse service, or in any health agency, is the patient. Numbers of patients, the particular needs of patients, the duration of stay of patients, these are our dictators. Hospitals at times have almost overwhelming numbers of such dictators, because ill citizens come to their hospital in need of the care the hospital was established to provide. We nurse patients 24 hours a day and 7 days a week because ill citizens do not go home daily at 5 o'clock or leave for the week-end on Friday.

So we have giving this care an interdependent group of people interested in cure and care of the sick, people whose organization is dictated by the consumer of the services. From the sequelae of this situation are derived the goals and plans for nursing.

Where will you as a student becoming educated in nursing fit into this scheme now? And you will come in time to this scheme to work somewhere as a graduate nurse. You will have had the best that your university can give over four short years in general education and in nursing. You will know more about science and medicine and nursing per se than was even dreamed of in my student years. Your cap which you receive tonight is a recognition of this knowledge now to be acquired. But it is more. Privilege in education like all privilege brings responsibility. Your predecessors in nursing gained their knowledge slowly, much of it through experience. Much that they discovered was discovered empirically, for they had no science techniques such as you will have. Having this you will have, too, the responsibility to study, to make

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sound plans, to develop realistic ways to meet the nursing needs. There will be a further responsibility to share with others also involved in the care; sharing not as one with wealth looks upon those with less, but in a kind of association in which both those who have and those who have less work and grow together, each respecting the others knowledge and ability. There will be demanded of you because you wear this cap more than knowledge and skill. Dedication will be expected also, dedication to the best which knowledge and skill can give, dedication which recognizes the shortcomings of our system of nursing today, and reacts not with criticism but in the spirit of nurse-scientist to seek the reason and to work toward the cure. My sincere good wishes to you all.

2-12-64

RS:BF

NEWTON-WELLESLEY HOSPITAL

SCHOOL OF NURSING

GRADUATION ADDRESS

RUTH SLEEPER, R.N.

SEPTEMBER 6, 1963

LOOKING IN ALL DIRECTIONS

Where is Nursing today? Where has it been? Where is it to go? What have been the progressive changes in nursing education, and what is to happen to our educational system in the future? These are all pertinent questions for the school of nursing which has completed seventy-five years of progress, and stands today on the threshold of one of the most challenging periods in the history of mankind. This is indeed the time to look in all directions: to take stock from the past; to learn from the present; and to forecast the changing patterns for the future.

Let me hasten to say that I do not propose to do all of this with you this afternoon. Ours can only be a suggestive glance. Considered answers to the question of where we have been, and are, and should go, can only be derived after much reading, study, and debate. The backward look is of necessity a long one, since modern nursing began over twenty-five years before Miss Mary E. Palmer admitted the first three students to this school. Nursing training as envisioned by Miss Nightingale was in reality a highly educative process. Though she spoke of training nurses, her objectives, the methods proposed, and the outcomes expected from the program, were far beyond the apprenticeship training. Hers was not an easy task. There was no system of education for women. There was no stated list of principles to guide her or the Matron selected for her school. But she knew how to select student nurses. She attracted young women of ability. She recognized the difference in individuals and planned so as to capitalize on these differences. She saw clearly the relationship of training or education and practice with

their interrelated stimulation. Furthermore, she recognized the opportunities in nursing practice for the student nurse to test her learning. In her plan training was rightly synonymous with education.

The Nightingale system came to this country eighty-one years ago. Early efforts promised well for the transference of the Nightingale plan to the New World. There was one great difference. America had no Florence Nightingale. There was no single counterpart with Miss Nightingale's leadership, vision, knowledge, influence and driving power. Perhaps a system so dependent on the knowledge and power of one woman is not compatible with the democratic process in our land. Whatever the reason, the Nightingale system was rapidly changed and adapted to meet the needs of a different social medium. Hospitals were founded in rapid succession as cities grew, and the social consciousness awakened to the needs of the sick. Training schools appeared to offer the best means to secure nursing services. So the schools grew in number as hospitals multiplied, and the educational objective too often was obscured. In 1873 there were founded three training schools; by 1900 there were 432; and in 1909 1,096. In the 1920's the number was to reach 2,135. It has in fact been said that had the objective of nursing education in these early years been defined it would have been not to train nurses, but to demonstrate that skilled nursing care was superior to unskilled.

Shortly before 1900, nursing leadership was aroused. Of this now there was no shortage. Superintendents of training schools aware of, in fact alarmed at, the unhealthy numerical growth of schools without the positive influence of sound standards and controls had begun to take action:

the Society of Superintendents of Training Schools, the forerunner of the National League of Nursing Education, and now one of the organizations joining to form the National League for Nursing was organized; the Associated Alumnae of Schools of Nursing, the forerunner of the American Nurses' Association followed; laws for licensure of nurses were passed in one State after another; a university course for administrators and teachers was inaugurated at Teachers College, Columbia University; communications between schools were made possible by the advent of the American Journal of Nursing. Wheels of progress were unmistakably in motion.

That changes came in rapid succession is of course apparent. Yet to those who were eager to reach the educational goal, the processes of change seemed to lag. Curriculum guides of various levels of educational sophistication were published in 1917, 1927, and 1937. Comprehensive studies to point out weaknesses to be eliminated and strengths to be fostered were published in 1918, 1934 and 1949 and 50. New concepts in education came with the introduction of the first university program for basic nursing education in 1909, the organization of the Association of Collegiate Schools of Nursing in 1933, the growth of the Associate Degree Programs through the 1950's and 60's; and the growth of the National League for Nursing's school improvement and accreditation programs.

Of equal importance to the changes themselves are without doubt the lessons that nursing leaders in our country in your school and mine have learned in the past seventy-five to one hundred years. Here again we should do well to turn to a portion of Miss Nightingale's philosophy: "the chief end of man is to work with the Creator in bringing order out of chaos, in transforming the world and also in transforming human nature," - that to bring such order "the laws of the universe must be understood including the laws of human nature and human well being."

We know indeed that nursing has a part to play in the great process of transforming the world to bring health into the darkest corners of our own and other lands. We know better than ever before that nurses must know how to help human nature to change. We know the pitfalls which can exist for nursing education when it is isolated from all other forms of education. We have seen the price demanded when nursing lacks strong, informed, and wise leadership. We have seen the need for nurses to guide the development of nursing and nursing education, working with able and interested partners in medicine, in education, and in society in general. We can better than ever before appreciate Miss Nightingale's plan. We can understand why she had for a period two groups of students, one with more educational background who went more often into administration or education, a second with good potential but less education who stayed more often in the hospitals. To be sure these two groups came then one from the higher social stratum and one from the common people as the English social order dictated. But the fact remains that breadth of education did prove a sounder foundation for positions of broad responsibility, and that as education for women improved the selective influences of English society gave way to criteria of ability and educational readiness.

For those who find in history guide posts for future planning, there is much of value. Let us now, however, turn to look at the present, at our own position in nursing education today. Developments during the first eighty-eight years of nursing in the United States have stirred currents, or trends which have proved in a sense revolutionary. The number of schools has dropped more than 1,000. The enrollment has risen. The annual output continues to grow slowly beyond the 30,000 level. The number of graduate nurses actively employed has reached 550,000, 175,000 more than in 1950.

A new system of education has evolved as many hospital-conducted schools sought to move away from the ineffective apprenticeship plan to meet educational criteria consistent with the times. Of the 1,118 basic programs in nursing, 191 are in colleges and universities and lead to a Bachelor's Degree. Fifty-four basic nursing programs are in junior colleges. A growing number of graduate nurses are enrolled in universities for advanced study in preparation for positions in administration, teaching, consultation or research.

On first glance it would appear that Nursing has arrived. A second look may expose the uncertainty, even the confusion, which continues in spite of progress. And one might well ask why. I do not really need to repeat these for a graduating class. You must already have discussed and faced the factors which will influence your graduate nursing practice: the advancing complexity of medicine, the almost daily discoveries in science, the changing socio-economic milieu in which we live and work, the growing and aging population, the increasing sophistication of the public in matters of health and welfare, and their growing demand for health care, and the evolving patterns of education for women.

I would ask you to examine carefully the influence of these and other factors on the care of patients. Nursing service and nursing education are and promise to continue to be inextricably intertwined. When more complex skills are expected of the practicing nurse or found by the critical nurse to be necessary, nursing education will take cognizance. As science and medicine demand more knowledge, more nurses will go to college to find it. New trends in education will involve nursing education, such as the junior college. It will follow naturally too that advanced programs in universities will be called upon to prepare administrators and teachers and research workers prepared to

plan and direct these different programs evolving in nursing education and nursing service.

We live truly in a changing medium. We are in a field in which research and general education constantly point the way to new and improved programs of patient care. So we in nursing must call upon our educational system to prepare nurses whose knowledge will be enduring and flexible enough to meet present and future demands.

Two years ago the Surgeon General of the Department of Health, Education, and Welfare appointed a Consultant Group "to advise him on nursing needs and to identify the appropriate role of the Federal Government in assuring adequate nursing services for our Nation." This spring the report was published. If you will now recall the brief list I gave of factors which will influence your practice as a graduate you will have in mind some of the major areas of concern which this Group considered. Many of their conclusions are self-evident: on the educational side, there are too few schools of nursing. There are not enough capable applicants recruited to nursing schools. Too few college students enter nursing. More nursing schools are needed in universities. On the nursing service side, there is a lag in the social and economic status of the nurse. There is a failure to use nursing personnel efficiently. There is a lack of research in the whole field of nursing practice.

Such a report tends always to shape developments within a profession or an occupational group. Without doubt both schools of nursing and nursing services are already questioning their present programs or studying to see wherein they can add, revise, or completely redesign. Where does this leave schools such as yours and mine? The Surgeon General's report urges an increase from 550,000 active nurses today to 680,000 by 1970. Large as this seems,

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it is 170,000 nurses below the number estimated as necessary for the growing population and the expanding medical and nursing programs by 1970. This increasing supply should come from all types of schools. In reading figures it is good to remember that figures out of context can be made to say pretty much what a speaker desires. Hence your need to read and analyze the statements in this report before you judge. Taken by percentage the basic collegiate programs should increase 98%, the diploma 58% and the associate degree 44%. This sounds to be sure as if the diploma programs were to be discouraged. But look at the numbers themselves. Collegiate programs are to graduate 8,000 when in 1961 they graduated just over 4,000, but it is a 98% increase. Junior College programs are to graduate 5,000, but this must be measured against the 917 graduated two years ago. The Diploma programs are to graduate 40,000 as against 25,300, numerically the largest increase.

Obviously the importance of our schools to the country's health has not been overlooked if we are to furnish 75% of the registered nurses. Your problem will not be the question of the importance of your school. Your problem will be what kind of a graduate should your school produce two - six - ten or more years in the future, and what you as a graduate of 1963 will contribute to the school's future potential.

Newton-Wellesley Hospital School of Nursing has been a part of a glorious tradition in nursing history. You for three years have been privileged to reap generously of the results which nursing leaders from your school achieved. As you look now in all directions - back to the school as you knew it, at the present as you stand on the threshold of your career, and forward toward the future which holds both problem and challenge, what do you see as your place in the whole scheme of nursing? Will you make the effort needed to develop

the endless patience, the quiet persistence, the dedication that Nursing will ask of you? Will you seek the necessary further education to keep in step with new advances? Will you help your school and your hospital to make whatever changes are essential so that the Newton-Wellesley Hospital may continue to contribute in whatever way is best to the preparation of nurses who can deal effectively with problems of sickness and health in the complicated world of the future?

RS:MF
9-5-63

GRADUATION ADDRESS

THE JOHNS HOPKINS HOSPITAL

SCHOOL OF NURSING

SUNDAY, SEPTEMBER 20, 1964

by

RUTH SLEEPER

It seems indeed trite to say to a group of young women about to be graduated that today you stand on the threshold of a new beginning. The trite, today often ignored because of familiarity, all too frequently holds a great truth. Graduation for you is not merely a stepping from student to practitioner. It is a forward step into a career, into a field of work. It is the assumption of new rights, new responsibilities, new obligations.

It is about these rights which become yours that I wish to speak most especially today. These rights are your inheritance. They are traditionally granted to the nurse by society. I am not thinking as I use this word of the rights defined by the American Nurses' Association in the Economic Security Program. Nor am I thinking of the inalienable rights granted to us, the citizens, by our Constitution. Nor do I refer to the rights listed by the United Nations as basic necessities for all free people.

I have in mind the rights which today's society, the world over, grants to the members of the health professions, grants to those who labor for better health of people everywhere. Especially I think now of the rights given to us who nurse the people of and in the United States. They derive from progress in the medical and social sciences. They have been won by nurses who did the daily work at home in the local community, and at times by nurses who responded to a national emergency. They come in part to your generation as an inheritance from your nurse forbears whose efforts to improve practice and education have made you today a group set apart in society. They are yours because nurses before you demonstrated an unique

vitality in action when demands seemed overwhelming, and a dependable sustaining power when the day by day requirements were necessarily repetitive, routine, and often dull. These rights are also yours because the National and Local Nursing Organizations held standards high and fostered the growth of the profession. And we cannot omit that women who pioneered in this and other early schools led the way for all.

Personal feeling for time is so relative. For you now, standing at the beginning of your career, the emergence of rights for the professional nurse doubtless seems slow. It is easy at your point in time to be impatient. However, impatience at this stage in your career, if it urges wise action, has great value. For me, as a nurse who has worked and watched developments in nursing for forty years, there is wonder that a profession, and for many years only a woman's profession, could have moved so far so fast. A comparison of the nursing profession with others will help to show not only our progress in education and practice, but the changing attitudes of public and the other health professions toward nursing. A comparison will show, too, how much nurses have gained because they met the public's need. Look at medicine or teaching, professions established centuries before Nursing was organized. Compare our accomplishments in a short ninety-one years. Look at the growth in numbers, in the changing quality of practice, in the contribution to community and national health, at our educational developments, our public recognition and our future potential.

Certain rights are shared of course by all members of the health team. Some are intimately involved in the daily work where roles merge, overlap, and some times conflict. The doctor, for example, has a right to expect the

optimum a nurse can offer of loyal assistance, understanding, and cooperation. The hospital administrator who represents the public and the patient in a somewhat different way also have the right to expect understanding, loyal cooperation, honest objective interpretation of hospital policies in times of emergency or public misunderstanding, or daily pressure for more patients and more patient care.

We, as nurses, on the other hand have a right to expect comparable return on the part of our co-workers, comparable loyalty, comparable cooperation, comparable understanding of weaknesses and strengths. Like the others we deserve support and respect for honest efforts as individuals, striving to give the best in care and to achieve progress as a profession in education, in practice, and in research.

These rights devolve from cooperative action with others. But society grants rights to us as individual nurses: the right to speak publicly for peoples' welfare, not just as a citizen but as one with authority, with special knowledge and skill; the right to use our nursing skills when we choose; the right to work anywhere in this country, yes almost anywhere in the world; the right to study and to search for the new. There are others, but let us stop with these: the right to speak, the right to use our skills at will, the right to work where we may choose, and the right ever to seek knowledge, to search, and to initiate new and better ways to use our nursing.

I mentioned earlier that roles - and rights of members of the health team merge in the daily contacts, and merging may conflict. To mention only the possible conflict between professional roles is to draw only a partial picture. For the ultimate goal of all members of the health team lies in the peoples' need: in the need of those who are well and seek guidance and assistance to stay well; in the need of those who are ill and helpless and

need someone to care for them during their incapacity; in the need of those who are handicapped and need someone to care about them, that they may live comfortable and effective lives. The fact that nursing with other groups shares a common goal shows why roles merge, and why conflicts may result. It also shows the strengths which can be found when people work together merging interests and efforts in spite of conflicts.

But what of the people for whom the team cares? Where do these fit in? The National League for Nursing has recently listed Seven Rights and Expectations of the Patient. I shall not name all seven. For our purposes today I have chosen only the first three. One, that he (the patient) will receive the nursing care necessary to help him regain or maintain his maximum degree of health. Two, that the nursing personnel who care for him are qualified through education, experience, and personality, to carry out the services for which they are responsible. Three, that the nursing personnel caring for him will be sensitive to his feelings and responsive to his needs.

Stating the patient's rights more succinctly: he has a right to care at the time he needs it, for so long as he requires it, and by nursing personnel who are qualified to meet his need. Let us now look at these patients collectively. Who are they, and where are they, and what kinds of care have they a right to expect?

Numerically in this country they are a growing segment of a rapidly growing population. They are men, women, and children, at home where TV, radio, and printed material maintain a high pressure program on health care and sickness prevention. The content of this program grows not only in volume but in validity. If the community is fortunate, there is also a visiting nurse who brings assistance in family illness, and instruction to add

knowledge and know-how. So the homemaker grows more sophisticated in her knowledge of medical care, and more concerned that her family have more of this care. These patients, or potential patients are at work, where labor policies offer more insurance for care in sickness, and where, if the industry if fortunate, an industrial nurse presents pertinent health education instruction as a part of the industry's care program. So the worker not only learns what should be done, but finds in his possession the financial assistance for himself and his family. These patients are in school, where courses in science and health education reveal new and tantalizing insights. If the school is fortunate, a qualified school nurse augments the school's sickness and first aid care by instruction. This again is carried home to add to the family's knowledge and stimulate its desire to have its full share of the community's services which will bring or maintain a healthy, secure, family group. Some of these patients go to hospitals. Here, as you know, the modern system of care is not confined to the disease associated therapy alone. Instead, as a part of total care,patient and family gain in knowledge of everyday health care in addition to the follow-up plan made for the patient's recovery and rehabilitation at home in his family group.

We are then faced with a steadily growing population which demands more hospital care. So the numerical demand brought by added population growth is intensified by the demand of all citizens who seek to have their rightful share. For example, we are told that in the past fifty years the nation's population has doubled, but the number of health workers employed to meet the patients' health requirements in hospitals alone has quadrupled. I do not say that only the growth in public knowledge has been responsible for this increase. There are many other important factors too. I would add however that these figures, which are actual statistics, show only the growth

that did occur, and cannot show what the growth should have been, had all the peoples' needs been met, and had every community been so fortunate as to have an adequate number of qualified nurses employed in its public health agencies, its industries, its schools, its hospitals, and its clinics.

I have emphasized, as I mentioned the nurses in home, industry, school, and hospital that "if they were qualified." The patient has the right to volume of care, but volume may be of little value if in quality the need is not fulfilled. It is like food which fills the stomach of the hungry child but lacks ingredients for normal nutrition to bring growth and happiness in health. Qualification is not the result only of study in schools or university. Qualification like a fabric is composed of warp and woof. Warp, like the knowledge leads the way, furnishes the basic threads in the fabric. But the fabric has no substance, no usefulness, until the woof fills in the spaces to hold the whole together. Experience after graduation in a hospital such as this can add the skill, mold student attitudes into professional philosophy, and provide a fabric which will endure.

I am not now discussing who - which category of nursing personnel should care for the patient. Nor am I to discuss what should be the ratio of professional nurses to other nursing personnel. I do not believe we have honestly learned up to now how best to assign the qualified nurse in relation to the practical nurse and aid. I do not believe we truly know which patients need most the skills of the qualified professional nurse. I believe the demand in hospitals, and this may well be true in other fields, has augmented so rapidly that we have only been able to cover the situation with personnel. In hospitals where more professional nurses have been available, patients have had

more care from nurses, but we are not sure this was always necessary. In hospitals where nurses were few the care was given by those who could be assigned, and unfortunately sometimes the nurse assigned was not qualified, or fortunately the aid chosen, though little taught, was kind, intelligent, and able to meet the need.

The fact remains the patient now in large numbers if ready by knowledge and by finances to demand his rights for care, and for qualified care. There is the third fact so often overlooked. He demands this care at any time of day, week, or year. Sometimes his need is an obvious emergency - an automobile accident. Sometimes the need urgent to him is less apparent to us. But if a homemaker can no longer care for her family because of varicose veins, so the family is to be neglected, her need becomes in the eyes of the family equally an emergency.

Perhaps it is time now to line up the rights of both nurses and patients. If I had a blackboard I would make two columns - one for patient - one for nurse.

I would list for patient	for nurse
the right to have care by qualified nurses or nursing personnel	the right to speak for public welfare
the right to have this care when he chooses	the right to study and search for the new - as she chooses
the right to have this care where he chooses	the right to use her skills as she chooses
	the right to work anywhere and everywhere as she chooses

Two of the nurse's rights may fit well with patients' expectation - the right to speak should protect both public and nurse, should bring increased community knowledge, should help to bring better facilities. The right to study and search for the new should merge with patients' expectations that nurses will grow increasingly more highly qualified; that they will when they understand want new methods, new patterns of nursing care, new programs of education. But the nurse's right to use skills as she chooses - what of this? Where will she choose to work - where the patients' needs are greatest or where her friends may go - where the critical, the strenuous need exists or where the load will be least demanding? And the choice of where to work - How can this be reconciled with patient need? Will the choice be made in terms of comfort and convenience for living or transportation? Will the choice be made in terms of hours which coincide best with those of friends and family?

There are so many factors to consider in these decision which you are facing today. You will face them in one way or another throughout your lives whether you make nursing your primary career, or whether nursing becomes the secondary career to home and family. Patients' rights should obviously be respected, or our people will lack care. And we must not forget this care can be a very personal matter, too, for amongst these people will be your own families and friends.

The rights of your medical co-workers must be considered - not only that medical practice may achieve its goal - but also because the future progress of medical science is heavily dependent on the skills of qualified nurses. Without these skills clinical research can be retarded, and the results of the research slow to implementation. I had in mind just now the research and practice of doctors, but programs in Social Service, Nutrition, and other medical fields could be equally hampered.

I have not mentioned the rights of other nursing personnel, but they are in their way no less important. Surely they have a right to expect enough nurses to care for the patients, nurses who are qualified to give highly skilled patient care, qualified to teach the auxiliary workers, qualified to differentiate the nursing elements in patient care and assign the worker to tasks appropriate to his knowledge and skill.

Obviously a life in nursing, whether it be a full time career or one secondary to family becomes a life of decision, a life of reconciling conflicts, personal, professional, social. It is indeed a life which requires insights into the causes of these conflicts, into ways and means for bringing reconciliation. It is a life for those who have vision to set and work toward a goal beyond self. It is a life which promises great rewards for those who have the courage of commitment, and it can hold personal fulfilment for those who do.

I should like to leave with you a short poem found in the biography of Amelia Earhart. This poem was written while she was a social worker in Boston, some time before her transoceanic flights were even dreamed of -

"Courage is the price which life exacts for granting peace,
The soul that knows it not, knows no release
From little things;

Knows not the livid lonliness of fear
Nor mountain heights, where bitter joy can hear
The sound of wings.

How can life grant us boon of living, compensate
For dull gray uglines and pregnant hate
Unless we dare.

The soul's dominion? Each time we make a choice we pay
With courage to behold resistless day
And count it fair."

9-15-64

ALBANY MEDICAL CENTER 125th ANNIVERSARY

Albany Medical College at the time of its founding

OCTOBER SECOND AND THIRD, 1964

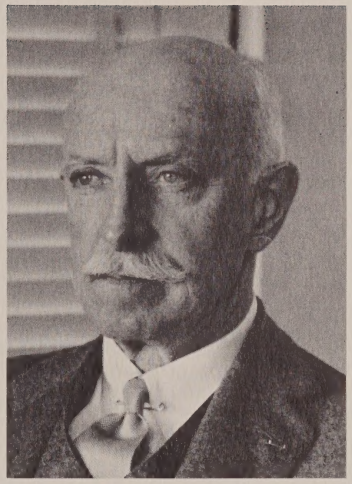
Greetings

We are convened to review the accomplishments of the past 125 years of medicine and medical education, to evaluate the current state of the nation's health, to suggest and define the direction that medicine should take in the years ahead.

As we conjure up the past, let us remember that we are doing so in order to give perspective to the present and stimulate our thinking about the future. I'm sure that the great men in our history would approve for they did not stop at making plans but took positive actions to improve the lot of mankind.

And so I welcome you in the spirit that this anniversary program is a beginning not an ending. As far as is known, this is the first time that a group of noted authorities has been assembled for a discussion and analysis of all aspects of the nation's health. It is an ambitious undertaking, one worthy of the event that it marks.

The future of medicine, the bright promise that it holds for mankind, should be more clear when these discussions are completed. We have every confidence that this purpose will be fulfilled, and that the 125th Anniversary Celebration of Albany Medical Center will be a memorable occasion.



Frank A. McNamee, Jr., *President*
Albany Medical Center Foundation

Program, Friday, October Second

12:30 P.M. Afternoon Session, DeWitt Clinton Hotel

Presiding, Frank A. McNamee, A.B.
Partner, Whalen, McNamee, Creble and Nichols
President, Albany Medical Center Foundation
Vice-President, Board of Trustees, Albany Medical College

Invocation: Rabbi Alvin S. Roth, A.B., Ph.D.
Congregation Beth Emeth
Albany, New York

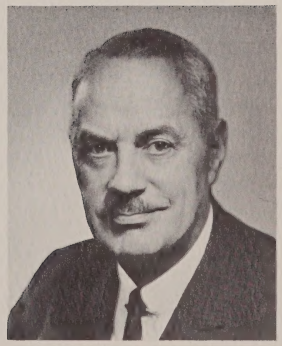
Greetings: The Honorable Erastus Corning II, A.B.
Mayor of the City of Albany, New York

Greetings: Carter Davidson, A.M., Ph.D., LL.D., Litt.D., L.H.D., Sc.D.
Chancellor, Union University

Address: "The Role of the Medical College in the Nation's Health"
Harold Carl Wiggers, A.B., Ph.D., Sc.D.
Dean, Albany Medical College

Address: "The Role of the Medical Center Hospital in the Nation's Health"
Thomas Hale, A.B., LL.B., M.D.
Administrative Vice-President and Director,
Albany Medical Center Hospital

Address: "The Role of the Community Hospital in the Nation's Health"
James Bordley, III, Ph.B., M.D., Sc.D.
Director, Mary Imogene Bassett Hospital, Cooperstown, New York
Clinical Professor of Medicine,
College of Physicians and Surgeons, Columbia University
Clinical Professor of Medicine, Albany Medical College



Carter Davidson

8:00 P.M. Evening Session, DeWitt Clinton Hotel

Presiding, Francis Bergan, A.B., LL.B., LL.D.
Associate Judge, Court of Appeals, State of New York
President, Board of Trustees, Albany Medical College
Vice-President, Albany Medical Center Hospital

Address: "The Role of the Pharmaceutical Industry in Research"
Theodore George Klumpp, B.S., M.D., D.Sc., LL.D.
President, Winthrop Laboratories

Address: "The Relationship Between the Pharmaceutical Industry and the Medical Profession"
Austin Smith, M.D., C.M., M.Sc., LL.D.
President, Pharmaceutical Manufacturers Association

Address: "The Economics of the Pharmaceutical Industry"
Francis Cabell Brown, LL.M., LL.D.
President, Schering Corporation

Saturday, October Third

9:00 A.M. Morning Session, DeWitt Clinton Hotel

Presiding, Edwin L. Crosby, A.B., M.D., M.P.H., Dr.P.H., D.Sc.
Executive Vice-President and Director, American Hospital Association
President, International Hospital Federation

Invocation: The Reverend J. Dean Dykstra, A.B., B.D., D.D.
Minister, The First Reformed Church of Schenectady, New York

Address: "The Organization of Medical Practice in the United Kingdom: The Relationship Between Specialists and General Practitioners"
The Right Honorable Lord Cohen of Birkenhead, P.R.S.M., P.R.S.H., M.D., D.Sc., LL.D., F.R.C.P., F.A.C.P.
President, General Medical Council
Professor of Medicine, University of Liverpool
President, Royal Society of Medicine

Francis Bergan

Address: "The Organization of Medical Practice in the United States: The Relationship Between Specialists and General Practitioners"
George Anthony Wolf, Jr., B.S., M.D.
Professor of Medicine and Vice-President for Medical and Dental Affairs, Tufts University
Executive Director, Tufts-New England Medical Center

Address: "Problems Facing Nursing in the United States"
Ruth Sleeper, R.N., B.S., M.A., L.H.D., D.Sc.
Director, School of Nursing and Nursing Service, Massachusetts General Hospital

12:30 P.M. Afternoon Session, DeWitt Clinton Hotel

Presiding, Arnold Cogswell, A.B.
President, Arnold Interests, Inc.
President, Albany Medical Center Hospital

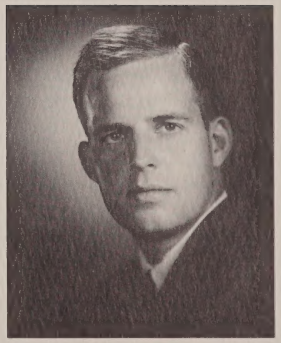
Invocation: The Reverend S. Edward Young, A.B., B.D.
Minister, First Presbyterian Church, Troy, New York

Greetings: James Edward Allen, Jr., A.B., Ed.D., D.P., L.H.D., LL.D., Litt.D.
Commissioner of Education, State of New York
President, University of the State of New York

Greetings: Richard Silman Folsom, M.S., Ph.D., Sc.D.
President, Rensselaer Polytechnic Institute
Affiliated with Albany Medical Center through the Joint Program for Bio-medical Education

Greetings: Lewis A. Froman, A.B., Ph.D.
President, Russell Sage College
Affiliated with Albany Medical Center through the Joint Programs for Nursing Education and Physical Therapy

Address: "The Role of Federal Agencies in the Nation's Health"
Luther Leonidas Terry, B.S., M.D., Sc.D.
Surgeon General, United States Public Health Service


Arnold Cogswell

Address: "The Role of State Agencies in the Nation's Health"
Hollis Steadman Ingraham, A.B., M.D., M.P.H.
Commissioner of Health, State of New York

Address: "The Role of Private Foundations in the Nation's Health"
Alexander Robertson, M.D.
Executive Director, Milbank Memorial Fund

8:00 P.M. Convocation, Chancellors Hall

Presiding, Carter Davidson, A.M., Ph.D., LL.D., Litt.D., L.H.D., Sc.D.
President, Union College
Chancellor, Union University

Processional

Invocation: The Right Reverend Allen Webster Brown, A.B., Th.M., D.D.
Bishop of the Episcopal Diocese of Albany, New York

Selections: Union College "Dutch Pipers"

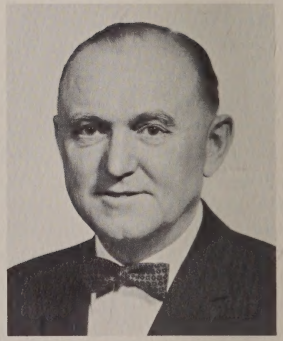
Address: "The Nation's Health"
The Honorable Abraham A. Ribicoff, LL.B., LL.D., L.H.D., H.H.D., J.D.
United States Senator from the State of Connecticut
Secretary of Health, Education and Welfare (1961-1962)
Governor, State of Connecticut (1955-1961)

Selections: Rensselaer Polytechnic Institute Glee Club

Conferring of Honorary Degrees: Chancellor Davidson
Degrees will be conferred in the order in which the names of the recipients appear upon the program

Benediction: The Most Reverend William A. Scully, D.D., LL.D.
Bishop of the Catholic Diocese of Albany, New York

Recessional
The audience is requested to remain seated until the procession has withdrawn from the hall.



Edwin L. Crosby

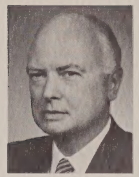
Recipients of Honorary Degrees

James Bordley, III

James Bordley, III, graduate of the Johns Hopkins School of Medicine and for twenty years a member of its staff, since 1947 Director of one of America's most distinguished community hospitals, Clinical Professor of Medicine at Albany Medical College who has been honored by election as President of the American Clinical and Climatological Association — the degree of Doctor of Science, Honoris Causa.

Theodore G. Klumpp

Theodore George Klumpp, scholarly son of Princeton and of Harvard Medical School, former Professor at Yale, Chief of the Drug Division of the Federal Food and Drug Administration, for the past twenty-two years President and Director of the Winthrop Laboratories, honored by colleagues with election as President of the National Pharmaceutical Council and President of the American Pharmaceutical Manufacturers Association — the degree of Doctor of Science, Honoris Causa.



Austin Smith

Austin Smith, neighbor from across the Canadian border who, after receiving a medical degree at Queens University, came to New York State to intern, for many years a staff member and Journal Editor of the American Medical Association, since 1959 President of the Pharmaceutical Manufacturers Association — the degree of Doctor of Science, Honoris Causa.

Francis C. Brown

Francis Cabell Brown, educated in the law at Georgetown and for twenty years a practicing lawyer and government official in the nation's capital, for the past twenty-one years President of a major drug corporation and honored by election as President of the American Pharmaceutical Manufacturers Association and Chairman of the Board of Project HOPE — the degree of Doctor of Science, Honoris Causa.

Lord Cohen of Birkenhead

The Right Honorable Lord Cohen of Birkenhead, recognized as the leader of the medical profession in Great Britain where he now serves as President of the General Medical Council, for forty years a distinguished researcher in Neurology and the Chemistry of the Cerebrospinal Fluid, for thirty years a Professor and Head of the Department of Medicine at Liverpool University, Knighted for scientific achievement yet active in the theatre — the degree of Doctor of Science, Honoris Causa.

George A. Wolf, Jr.

George Anthony Wolf, Jr., President-Elect of the Association of American Medical Colleges, prepared at New York University and Cornell Medical College, Professor of Clinical Medicine at Cornell and later Dean of the University of Vermont College of Medicine, now Director of one of America's most impressive medical centers and Vice President of Tufts University — the degree of Doctor of Science, Honoris Causa.

RUTH SLEEPER

Ruth Sleeper, outstanding educator of the profession of nursing, now and for eighteen years Director of the School of Nursing and Nursing Service at Massachusetts General Hospital where she received her own training, honored by her colleagues by election for several terms as President of both the National League of Nursing Education and the National League for Nursing, active in the international field, recipient in 1959 of the Florence Nightingale Award — the degree of Doctor of Science, Honoris Causa.

LUTHER L. TERRY

Luther Leonidas Terry, brilliant cardiovascular researcher and leader in public health, born and educated in the South, Professor at the University of Texas and Johns Hopkins Medical Schools, Chief of the Clinic at the National Heart Institute at Bethesda, and now Surgeon General of the United States Public Health Service, the director of our nation's efforts to improve the health of America — the degree of Doctor of Science, Honoris Causa.

HOLLIS S. INGRAHAM

Hollis Steadman Ingraham, Epidemiologist extraordinary, trained at Harvard, for thirty years a staff member of the New York State Department of Health and now Commissioner of Health, a Professor of Community Health at Albany Medical College and Chairman of the Board of Health Research — the degree of Doctor of Science, Honoris Causa.

ALEXANDER ROBERTSON

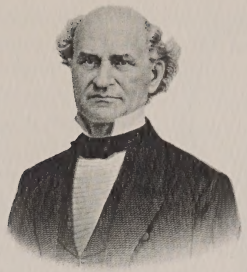
Alexander Robertson, pioneering integrator of the Behavioral Sciences with Medicine, Scotsman born and Edinburgh educated, active in public health education in Great Britain at the London School of Hygiene and as Past President of the Royal Medical Society, in Canada as Professor and Head of Social and Preventive Medicine at the University of Saskatchewan, and now in the United States as Executive Director of the Milbank Memorial Fund — the degree of Doctor of Science, Honoris Causa.

ABRAHAM A. RIBICOFF

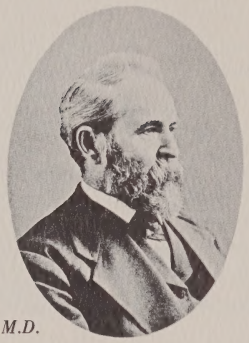
Abraham Alexander Ribicoff, triple-threat halfback of the American political scene, shifting smoothly from Judge to Congressman to Governor to Cabinet Member to United States Senator, throughout winning the admiration and respect of all for legal acumen, hard work, political sagacity, and above these for social conscience — the degree of Doctor of Laws, Honoris Causa.

History of the Albany Medical Center

The city of Albany, founded in 1614, was a strategic crossroads in America's early wars, and served as a regional medical center caring for the sick and wounded on both sides in the French and Indian War and the American Revolution. With this medical heritage, it was logical that the city would one day become the home of a medical school and medical center serving the needs of eastern New York. The first step in the development of the patient care, teaching and research complex known today as Albany Medical Center was the founding of Albany Medical College in 1839.



Alden March, M.D.

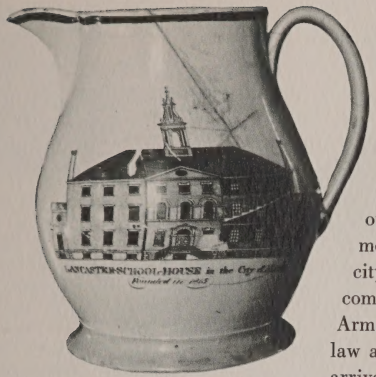


James Armsby, M.D.

Albany Medical College

The efforts of one man, more than any other, brought the Albany Medical College—the first unit of what has become the Albany Medical Center—into existence. That man was Dr. Alden March, who came to Albany in 1820, fresh from completing his medical studies at Brown University. That Dr. March was something of a crusading pedant may be detected from the fact that, within a year of his arrival in Albany, he opened a one-room school for instruction in anatomy. Soon, Dr. March was urging the establishment of a school of medicine in Albany, one that would provide the city and surrounding area with trained physicians. At first, Dr. March's pleas went unheeded. And when he petitioned the State Legislature to charter an Albany Medical College, the two medical schools then

Albany Medical College, circa 1900



extant in the state blocked action on the measure. However, Dr. March persevered, and his cause was aided by the cholera outbreaks of 1832 and 1834, which caused the death of several hundred people in Albany and pointed out the need for more and better medical care in and around the city. Additional aid was forthcoming in the person of Dr. James Armsby, Dr. March's brother-in-law and a persuasive lecturer, who arrived in Albany to assist Dr. March. One of Dr. Armsby's contributions was a series of public lectures on scientific subjects. Many of the city's prominent citizens attended these lectures and, in 1837, moved by Dr. Armsby's oratory, they formed committees and began a serious effort for the establishment of an Albany Medical College. The city government lent a hand by donating the empty Lancaster School building and, on January 2, 1839, the Albany Medical College opened its doors for the first time. A few weeks later the State Legislature gave its official blessing, granting the charter that Dr. March had so persistently sought.

Fifty-seven students were enrolled in the first class, and the faculty included Dr. March, President and Professor of Surgery, and Dr. Armsby, Professor of Anatomy and Physiology. Ten years later, Doctors March and Armsby influenced a number of Albany's leading citizens to incorporate the Albany Hospital, thus beginning the clinical affiliation between college and hospital that exists today.

Dr. March continued as President of the College until his death in 1869, and Dr. Armsby was President in 1875, the year of his death. In 1873, the trustees of the Medical College, recognizing the importance of a university affiliation, joined with Union College, located in nearby Schenectady, in the formation of Union University, which also includes the Albany Law School, Albany College of Pharmacy and Dudley Observatory. The Medical College was housed in its original home in the old Lancaster School until 1928, when it moved into a modern five-story building on New Scotland Avenue adjacent to Albany Hospital.

In 1963 Albany Medical College more than doubled the size of its physical plant with the completion of a five-story, $5,000,000 Medical Science Building. The structure, which connects directly with the existing main building, is primarily devoted to research laboratories and related facilities, and also includes several classrooms, a large student laboratory, bookstore and administrative offices. At the same time this building was erected, teaching facilities in the 1928 building underwent extensive modernization.

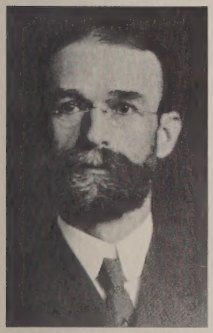
Despite many changes in its 125 years of existence, Albany Medical College has maintained its policy of limiting classes to a small group of highly selected students (there were 57 students in the first class, and 65 in the class of 1967, enrolled last year). The College is a private, non-denominational and co-educational institution. Its student body numbers about 250 and there are some 500 full- and part-time faculty members.

In addition to the study of medicine, the College offers a graduate study program in the basic medical sciences. With Russell Sage College in Troy, N. Y., it operates a School of Physical Therapy.
The College can point with pride to many distinguished alumni. These include: John Swinburne, Class of 1846, Health Officer of the

Port of New York and member of Congress (Swinburne Island in New York Harbor is named in his honor); James H. Salisbury, Class of 1850, author of many papers on diet and nutrition and the man after whom the Salisbury Steak is named; Theobald Smith, Class of 1883, a pioneer in Bacteriology who discovered the cycle of transmission of infectious disease via an insect carrier, thus solving the mystery of malaria, yellow fever and similar human diseases; Thomas W. Salmon, Class of 1899, Medical Director of the National Committee for Mental Hygiene and Senior Consultant in Neuro-Psychiatry to American Expeditionary Forces in World War I; Kenneth D. Blackfan, Class of 1905, Professor of Pediatrics at Harvard Medical School from 1923 to 1941; and Edwin L. Crosby, Class of 1933, Executive Vice-President and Director of the American Hospital Association.

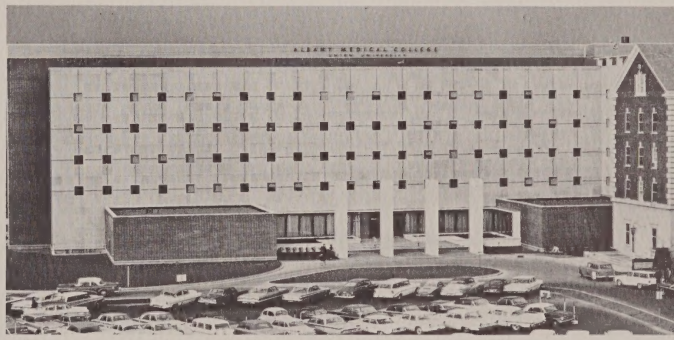
In the last 10-15 years Albany Medical College has undergone substantial growth. This growth has included faculty and employees, who have tripled in number, and research and teaching programs. The large volume of research in progress is evident in the fact that the College last year received nearly $2,500,000 in research grants from federal and other sources. This year the College will activate a clinical research center for the laboratory-like bedside study of human illness.

Within the last year a number of new educational programs have been inaugurated. The College's teaching resources have been joined with those of Rensselaer Polytechnic Institute, the nation's oldest school of science and engineering, to offer a biomedical education program. Under this program, selected high school graduates will



Theobald Smith, M.D.

Albany Medical College, 1928

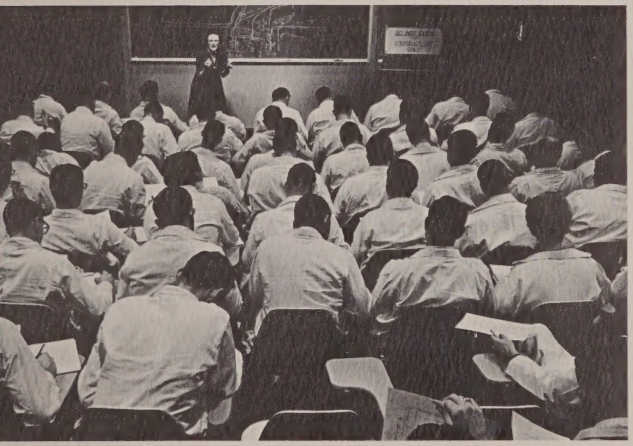


Albany Medical College, 1964

study at Rensselaer and Albany, acquiring a B.S. degree and M.D. degree at the end of six calendar years. It is the aim of this accelerated program to reduce the time necessary to acquire an M.D. degree, to provide the student with a superior background in the fundamental sciences and to develop research-oriented physicians. Also within the last year, the College and New York State Health Department have formed an Institute of Preventive Medicine, which is designed to promote collaborative efforts in research and education on the part of the professional staffs of the two institutions.

Albany Medical College has won wide recognition for its development of two-way radio communications as a medium for bringing postgraduate educational programs to busy practicing physicians. The College maintains its own FM radio station. Through it and affiliated stations on the eastern seaboard, the College broadcasts these medical programs to some 60 hospitals in six eastern states, and has fostered four similar medical radio networks in other parts of the country.

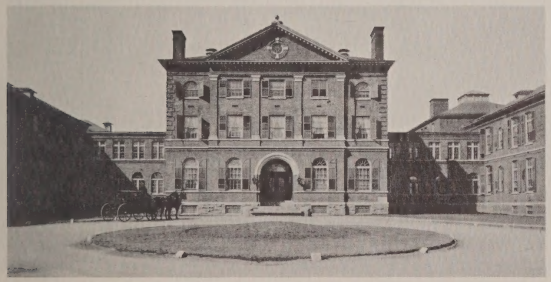
For the future, Albany Medical College and the New York State Education Department are studying the possibility of building a new State Medical Library on land provided by and contiguous to the College. The Medical College and Albany Law School are considering the erection of a dormitory for law and medical students.



Anatomy Lecture

Albany Medical Center Hospital

Building occupied by Albany Hospital, 1854-1899



Entrance to Albany Hospital, circa 1900

In 1849, Albany Hospital was incorporated as the first private hospital in the State outside of New York City. At the urging of Dr. March and Dr. Armsby, the incorporators undertook a drive to raise funds to pay for a hospital and dispensary. Albany at this time was a city of about 20,000 population. The first Albany Hospital was established in 1851 in a rented building on the corner of Madison Avenue (then Lydius Street) and Dove Street. The incorporators continued their fund drive and in May, 1852, they purchased, for $9,000, the former county jail building on the corner of Eagle and Daniels Streets. This building was repaired and equipped for hospital use, and was opened to patients in 1854.

For many years after its opening, the Hospital was in financial difficulty, as evidenced by the fact that the governors of the Hospital had to borrow $2,000 to meet the Hospital's debts in 1855. During the Civil War, temporary hospital barracks were erected by Albany Hospital authorities to care for wounded soldiers, many of whom were brought to Albany from the war zone by steamers.

By 1872, the Hospital had completed two additions and a nearby house was acquired and converted into an eye and ear infirmary and general dispensary. The Hospital at this time had a capacity of 131 beds, and a medical staff of 21 physicians, three of whom were residents. By 1876 the Hospital was deep in debt and appealed to the public for funds. The appeal was apparently unsuccessful because, in June of 1877, the sheriff closed the Hospital for unpaid debts of $5,000. The Hospital did not reopen until the following January, when the debts, except for a mortgage of $24,000, had been paid

through the efforts of "the medical gentlemen connected with the Hospital."

The mortgage was finally paid after the Hospital conducted a large bazaar in 1882. By 1890, the number of patients receiving treatment in the Hospital had increased to such a degree that the board of governors began to consider enlargement and relocation of the Hospital.

In 1897 solicitation of funds for a new hospital brought gifts and pledges of $230,000 from the people of Albany. The Park Commission granted the Hospital a parcel of land on New Scotland Avenue, and on this property a pavilion-type hospital was begun in 1898. The new Hospital was opened on May 15, 1899. The building included a wing for the nursing school which the Hospital had commissioned in 1896.

During the next few years, several important additions were made, including the Mosher Memorial Pavilion, completed in 1902 and the first psychiatric unit attached to a general hospital in the United States. A contagious disease building—now the Hun Memorial Tuberculosis Pavilion—was opened in 1903. By 1908 the Hospital was so far in debt that it had to appeal to the City and County governments for an appropriation "to pay the cost of board of all patients sent to the Hospital."

During World War I, the medical staff of the Hospital formed Base Hospital 33, which served with distinction in England.

The year 1928 marked an important turning point in the history of the Hospital. In this year the Hospital took the original step in the establishment of the Albany Medical Center, by concluding an agreement with the Albany Medical College which called for the College to erect its new building at the west end of the Hospital. At the same time, the Hospital built a new main wing, increasing its capacity to about 420 beds.

A number of improvements were made in the Hospital during the 1930s, but only a large legacy from the estate of George C. Hawley saved the Hospital from financial calamity during this period of economic depression.

In World War II, the medical staff again answered the call to colors, serving as the nucleus of the 33rd General Hospital Unit, which was assigned to North Africa and Italy.

The next major expansion of the Hospital occurred in 1951. This was the addition of the west wing, which brought the Hospital's capacity to its present level of 614 beds and 56 bassinets, and added new surgical, outpatient and emergency room facilities. In 1960, the Hospital formally adopted the name "Albany Medical Center Hospital."

Female ward, "D" pavilion, at turn of century

Within the last six years, Albany Medical Center Hospital has undertaken a capital expansion program which will make it the largest private hospital in the State outside of New York City. A nursing education complex was completed in 1958, a student nurse dormitory was opened in 1960, and last year saw completion of a house staff dormitory as well as an addition to the student nurse dormitory. Under construction and scheduled for completion in 1965 is an eight-story addition which will give the Hospital an 800-bed capacity. Another eight-story wing will be started in the near future. These new facilities will permit the Hospital to raze the old turn-of-the-century pavilions, including the Mosher and Hun Pavilions.

Albany Medical Center Hospital is a regional institution, serving some 2,000,000 residents of eastern New York and western New England and providing many medical and surgical services unduplicated by other hospitals in this area. Of the 24,000 patients admitted to the Hospital each year, about 9,000, or 36 percent, come from communities outside Albany County.

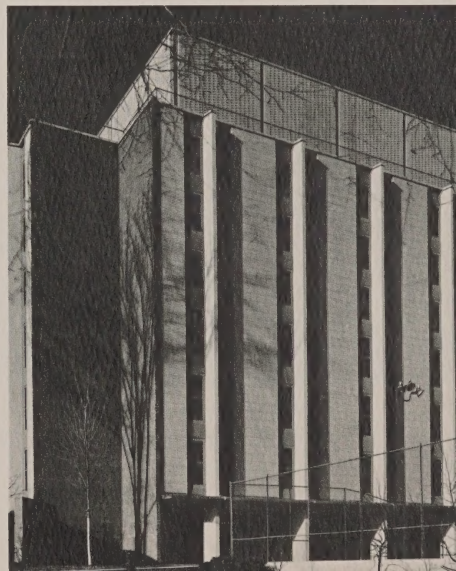
In 1963 there were 45,000 outpatient visits to the Hospital's clinics and 30,000 people were treated in the emergency room. Also last year, 9,700 operations were performed, of which 803 were neurosurgical operations and 66 were open-heart operations. A total of 1,150,000 meals was served to patients, employees and students, and the average daily census was 637.

The Albany Medical Center Hospital of 1964 has 165 young physicians—interns and residents—on its house staff, 300 student nurses, 1500 full-time employees and an annual operating budget of $12,000,000.

From a makeshift hospital housed in a former jail has emerged a modern medical center hospital which today fulfills challenging responsibilities in the fields of medical care, teaching and research.

Albany Hospital, 1929

House Staff Dormitory, 1964



School of Nursing

On December 7, 1896, the Albany Hospital completed negotiations with "a group of ladies" at 64 Howard Street, the conditions being that these ladies would "furnish all nursing in the Hospital in return for the sum of $420 a month, and the Hospital would provide board for not over 25 nurses and scholars." This marked the beginning of the Albany Training School for Nurses.

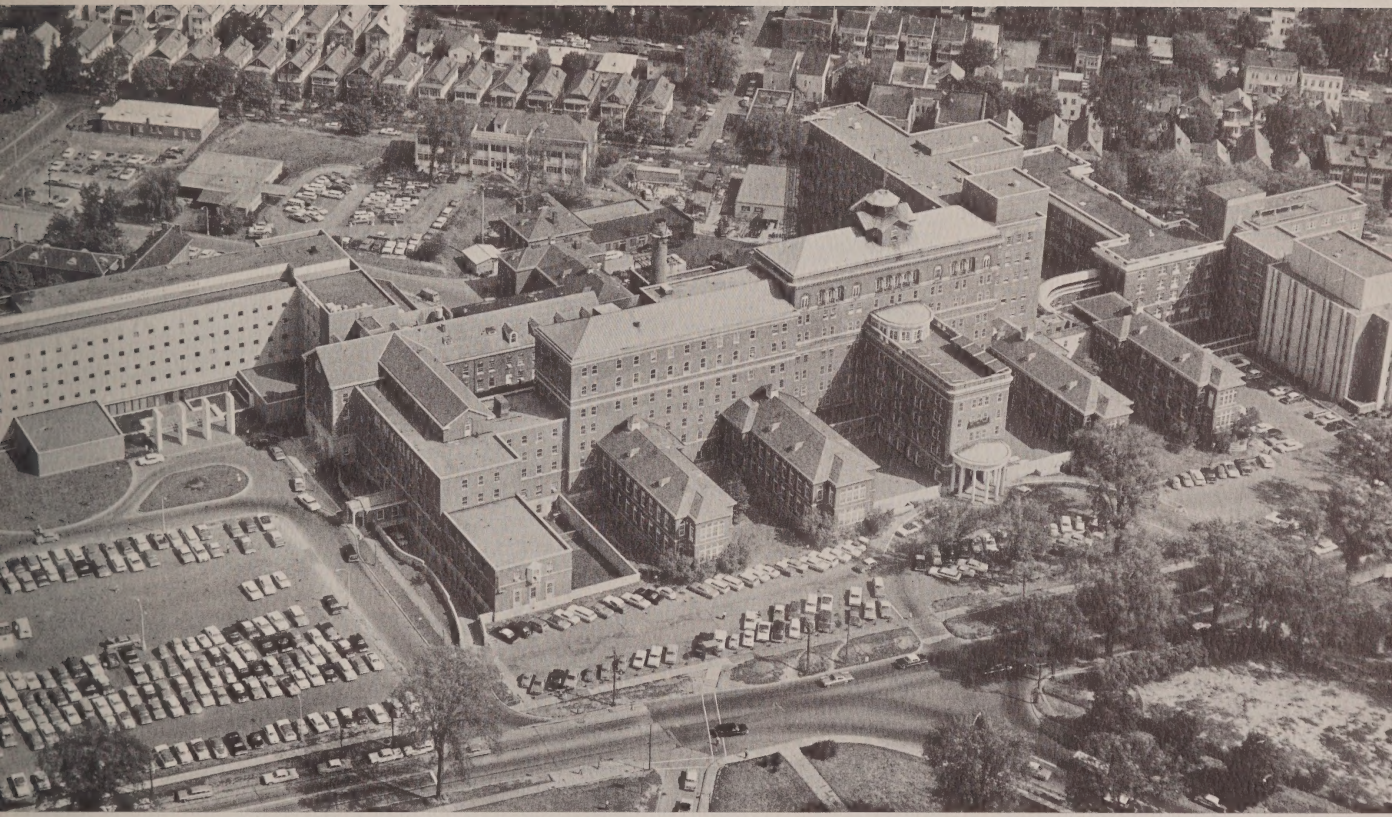
Subsequently, there have been two collegiate schools of nursing affiliated with the Hospital: the Russell Sage College School of Nursing and the Union University School of Nursing. In 1955 the Board of Governors of the Hospital established the Albany Medical Center School of Nursing, a three-year diploma school. Thus has the Albany Training School for Nurses evolved into the Albany Medical Center School of Nursing.

The School today has some 30 faculty members, about 300 students, and a modern physical plant, most of which has been built in the last six years. The students of the School receive all of their clinical training at the Albany Medical Center Hospital, and most of the School's graduates practice their profession in Albany and surrounding area.

Albany Medical Center

The Albany Medical Center of today is really three institutions—Albany Medical College, Albany Medical Center Hospital and Albany Medical Center School of Nursing—merged into one. Close affiliations are also maintained with the Albany Veterans Administration Hospital and the New York State Department of Health, both of which are located nearby.

On the occasion of its 125th Anniversary, the Medical Center is proud of its role as the principal source of physicians, nurses and advanced medical science for all of the people of eastern New York State.



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Amasa J. Parker	1875–1888
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James F. Adams	1954–1964
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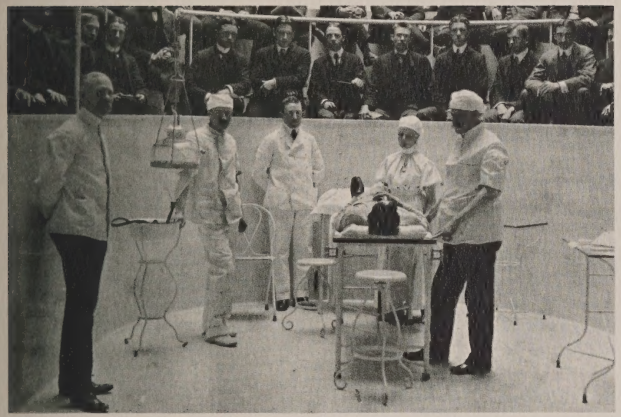
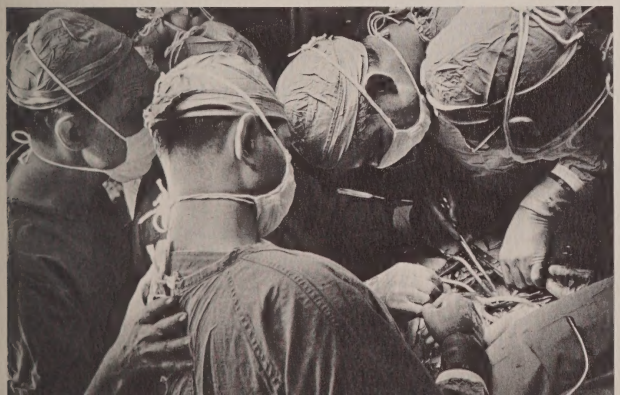
E. W. Jones	1935–1942
Robert S. Cunningham, M.D.	1942–1946
Thomas Hale, M.D.	1946–

Surgical Amphitheatre, 1902



Open-Heart Surgery Today



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